

**§ 431.806 State plan requirements.**

(a) *MEQC program.* A State plan must provide for operating a Medicaid eligibility quality control program that meets the requirements of §§ 431.810 through 431.822 of this subpart.

(b) *Use of PERM data.* A State plan must provide for operating a Medicaid eligibility quality control program that is in accordance with § 431.978 through § 431.988 of this part to meet the requirements of § 431.810 through § 431.822 of this subpart when a State is in their PERM year.

(c) *Claims processing assessment system.* Except in a State that has an approved Medicaid Management Information System (MMIS) under subpart C of part 433 of this subchapter, a State plan must provide for operating a Medicaid quality control claims processing assessment system that meets the requirements of §§ 431.830 through 431.836 of this subpart.

[55 FR 22166, May 31, 1990, as amended at 75 FR 48847, Aug. 11, 2010]

**§ 431.808 Protection of beneficiary rights.**

Any individual performing activities under the MEQC program or the claims processing assessment system specified in this subpart must do so in a manner that is consistent with the provisions of §§ 435.902 and 436.901 of this subchapter concerning the rights of beneficiaries.

**MEDICAID ELIGIBILITY QUALITY CONTROL (MEQC) PROGRAM**

SOURCE: Sections 431.810 through 431.822 appear at 55 FR 22167, May 31, 1990, unless otherwise noted.

**§ 431.810 Basic elements of the Medicaid eligibility quality control (MEQC) program.**

(a) *General requirements.* The agency must operate the MEQC program in accordance with this section and §§ 431.812 through 431.822 and other instructions established by CMS.

(b) *Review requirements.* The agency must conduct MEQC reviews in accordance with the requirements specified in § 431.812 and other instructions established by CMS.

(c) *Sampling requirements.* The agency must conduct MEQC sampling in accordance with the requirements specified in § 431.814 and other instructions established by CMS.

**§ 431.812 Review procedures.**

(a) *Active case reviews.* (1) Except as provided in paragraph (a)(2) of this section, the agency must review all active cases selected from the State agency's lists of cases authorized eligible for the review month, to determine if the cases were eligible for services during all or part of the month under review, and, if appropriate, whether the proper amount of beneficiary liability was computed.

(2) The agency is not required to conduct reviews of the following cases:

(i) Supplemental Security Income (SSI) beneficiary cases in States with contracts under section 1634 of the Act for determining Medicaid eligibility.

(ii) Foster care and adoption assistance cases under title IV-E of the Act found eligible for Medicaid.

(iii) Cases under programs that are 100 percent federally funded.

(b) *Negative case reviews.* Except as provided in paragraph (c) of this section, or unless a State is utilizing an approved sampling plan to conduct negative case action reviews under § 431.978(a) and § 431.980(b), the agency must review those negative cases selected from the State agency's list of cases that are denied, suspended, or terminated in the review month to determine if the reason for the denial, suspension, or termination was correct and if requirements for timely notice of negative action were met. A State's negative case sample size is determined on the basis of the number of negative case actions in the universe.

(iv) Individuals whose eligibility was determined under a State's option under section 1902(e)(13) of the Act.

(c) *Alternate systems of negative case reviews—(1) Basic provision.* A State may be exempt from the negative case review requirements specified in paragraphs (b) and (e)(2) of this section and in § 431.814(d) upon CMS's approval of a plan for the use of a superior system.

(2) *Submittal of plan for alternate system.* An agency must submit its plan for the use of a superior system to CMS

for approval at least 60 days before the beginning of the review period in which it is to be implemented. If a plan is unchanged from a previous period, the agency is not required to resubmit it.

The agency must receive approval for a plan before it can be implemented.

(3) *Requirement for alternate system.* To be approved, the State's plan must—

(i) Clearly define the purpose of the system and demonstrate how the system is superior to the current negative case review requirements.

(ii) Contain a methodology for identifying significant problem areas that could result in erroneous denials, suspensions, and terminations of applicants and beneficiaries. Problem areas selected for review must contain at least as many applicants and beneficiaries as were included in the negative case sample size previously required for the State.

(iii) Provide a detailed methodology describing how the extent of the problem area will be measured through sampling and review procedures, the findings expected from the review, and planned corrective actions to resolve the problem.

(iv) Include documentation supporting the use of the system methodology. Documentation must include the timeframes under which the system will be operated.

(v) Provide a superior means of monitoring denials, terminations, and suspensions than that required under paragraph (b) of this section.

(vi) Provide a statistically valid error rate that can be projected to the universe that is being studied.

(d) *Reviews for erroneous payments.* The agency must review all claims for services furnished during the review month and paid within 4 months of the review month to all members of each active case related in the sample to identify erroneous payments resulting from—

(1) Ineligibility for Medicaid;

(2) Ineligibility for certain Medicaid services; and

(3) beneficiary understated or overstated liability.

(e) *Reviews for verification of eligibility status.* The agency must collect and verify all information necessary to determine the eligibility status of each

individual included in an active case selected in the sample as of the review month and whether Medicaid payments were for services which the individual was eligible to receive.

The agency must apply the administrative period described in § 431.804 when considering the case circumstances and the case correctness. In order to verify eligibility information, the agency must—

(1) Examine and analyze each case record for all cases under review to establish what information is available for use in determining eligibility in the review month;

(2) Conduct field investigations including in-person beneficiary interviews for each case in the active case sample, and conduct in-person interviews only when the correctness of the agency action cannot be determined by review of the case record with beneficiaries for cases in the negative case action sample (unless this is otherwise addressed in a superior system provided for in paragraph (c)(1) of this section);

(3) Verify all appropriate elements of eligibility for active cases through at least one primary source of evidence or two secondary sources of evidence as defined by CMS by documentation or by collateral contacts as required, or both, and fully record the information on the appropriate forms;

(4) Determine the basis on which eligibility was established and the eligibility status of the active case and each case member;

(5) Collect copies of State paid claims or beneficiary profiles for services delivered during the review month and, if indicated, any months prior to the review month in the agency's selected spenddown period, for all members of the active case under review;

(6) Associate dollar values with eligibility status for each active case under review; and

(7) Complete the payment, case, and review information for all individuals in the active case under review on the appropriate forms.

(f) *Substitution of PERM data.*

(1) A State in its Payment Error Rate Measurement (PERM) year may elect to substitute the random sample of selected cases, eligibility review

findings, and payment review findings obtained through PERM reviews conducted in accordance with §431.978 through §431.988 of this part for data required in this section, if the only exclusions are those set forth in §431.978(d)(1) of this part.

(2) PERM cases cited as undetermined may be dropped when calculating MEQC error rates if reasons for drops are acceptable reasons listed in the State Medicaid Manual.

[55 FR 22167, May 31, 1990, as amended at 72 FR 50513, Aug. 31, 2007; 75 FR 48847, Aug. 11, 2010]

#### **§431.814 Sampling plan and procedures.**

(a) *Plan approval.* The agency must submit a basic MEQC sampling plan (or revisions to a current plan) that meets the requirements of this section to the appropriate CMS regional office for approval at least 60 days before the beginning of the review period in which it is to be implemented. If a plan is unchanged from a previous period, the agency is not required to resubmit the entire plan. Universe estimates and sampling intervals are required 2 weeks before the first monthly sample selection for each review period. The agency must receive approval for a plan before it can be implemented.

(b) *Plan requirements.* The agency must have an approved sampling plan in effect for the full 6-month sampling period that includes the following:

- (1) The population to be sampled;
- (2) The list(s) from which the sample is selected and the following characteristics of the list(s):
  - (i) Sources;
  - (ii) All types of cases in the selection lists;
  - (iii) Accuracy and completeness of sample lists in reference to the population(s) of interest;
  - (iv) Whether or not the selection list was constructed by combining more than one list;
  - (v) The form of the selection list (whether the list or part of the list is automated);
  - (vi) Frequency and length of delays in updating the selection lists or their sources;
  - (vii) Number of items on the lists and proportion of listed-in-error items;

(viii) Methods of deleting unwanted items from the selection lists; and

(ix) Structure of the selection lists.

(3) The sample size, including the minimum number of reviews to be completed and the expected number of cases to be selected. Minimum sample sizes are based on the State's relative level of Medicaid annual expenditures for services for active cases, and on the total number of negative case actions in the universe for negative cases. When the sample is substratified, there can be no fewer than 75 cases in each substratum, except as provided in paragraph (c) of this section or as provided in an exception documented in an approved sampling plan which contains a statement accepting the precision and reliability of the reduced sample.

(4) The sample selection procedure. Systematic random sampling is recommended. Alternative procedures must provide a representative sample, conform to principles of probability sampling, and yield estimates with the same or better precision than achieved in systematic random sampling.

(5) Procedures used to identify amounts paid for services received in the review month.

(6) Specification as to whether the agency chooses to—

(i) Use billed amounts to offset beneficiary liability toward cost of care (No indication will be interpreted to mean that the agency will use paid claims); and

(ii) Use denied claims to offset beneficiary liability toward cost of care in the payment review. (No indication will be interpreted to mean denied claims will not be used.)

(7) Indication of whether the agency opts to drop or complete cases selected more than once in a sample period. (No indication will be interpreted to mean that the agency will complete cases selected more than once.)

(c) *Eligibility universe—active cases.* The MEQC universe for active cases must be divided into two strata, the Aid to Families with Dependent Children (AFDC) stratum and the Medical Assistance Only (MAO) stratum.

(1) All States must use the AFDC quality control sample for the AFDC stratum.